Parental Substance Misuse in Norfolk:
How effectively has NSCB Safeguarding Protocol 10 been implemented?

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Terms
- The word ‘Parent’ is used to mean both parents and carers.
- The word ‘Child’ is used to mean both children and young people (anyone under the age of 18).
- Drug and alcohol (D&A) worker and substance misuse worker are terms used interchangeably.

Note: The font colours of the quotes have been used to make the professional group of the person making the quote more clear, black is used for substance misuse workers, blue for health and green for Children’s Services.

Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CAF</td>
<td>Common Assessment Framework</td>
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<tr>
<td>CADS</td>
<td>Community Alcohol and Drug Service</td>
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<td>CAMHS</td>
<td>Child and Adolescent Mental Health Service</td>
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<tr>
<td>CARAT</td>
<td>Counselling, Assessment, Referral, Advice and Throughcare’ (CARAT workers are based in prisons and act as keyworkers and coordinate the drug treatment of those prisoners on their caseloads).</td>
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<tr>
<td>CJIT</td>
<td>Criminal Justice Intervention Team</td>
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<td>D&amp;A</td>
<td>Drug and alcohol</td>
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<td>DAAT</td>
<td>Drug and Alcohol Action Team</td>
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<td>FIP</td>
<td>Family Intervention Project</td>
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<tr>
<td>N-DAP</td>
<td>Norfolk Drug and Alcohol Partnership</td>
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<td>NDTMS</td>
<td>National Drug Treatment Monitoring System (all DAAT commissioned services return data to a central point)</td>
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<td>NSCB</td>
<td>Norfolk Safeguarding Children Board</td>
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<td>NTA</td>
<td>National Treatment Agency for Substance Misuse</td>
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<td>PCT</td>
<td>Primary Care Trust</td>
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<td>SCR</td>
<td>Serious Case Review</td>
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<td>TADS</td>
<td>Trust Alcohol and Drugs Service</td>
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<td>UKDPC</td>
<td>United Kingdom Drug Policy Commission</td>
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Introduction

“Multi-disciplinary working with families is a complex and demanding process but it can be successfully managed if clear support and guidance are provided” (Frost and Robinson 2007)

In 2009, a serious case review was published by Norfolk Local Safeguarding Children Board (NSCB) into the serious sexual assault of a twelve year old girl referred to as CC. CC’s mother had been known to drug treatment among other services for most of the girl’s life and information about the family was held by various agencies. The review found that if this information had been put together at an earlier date the risk to CC would have become clear and services would have been provided, which could have prevented the assault. A protocol exists in Norfolk that sets out the potential effects of substance misuse on a parent and the actions that should be taken by all professionals involved in a case of parental substance misuse.

NSCB Protocol 10 covers the principles of working together to provide services for children, young people and parents whose substance misuse is a concern, however in reference to the serious case review this study focuses on parental substance misuse. The protocol emphasises the need to make assessments of a parent’s substance misuse and the impact this has on the child using the Common Assessment Framework (CAF). It also states that when significant harm is suspected, a referral should be made to Norfolk Children’s Social Services and that everyone is required to work with Children’s Services as appropriate, to share information and attend child protection conferences (see Appendix 1 for the main points of Protocol 10 in flow-chart form). Protocol 10 sets out the importance of a multi-agency response to safeguarding; this research will focus on these processes and the experiences of the various professionals involved.

A copy of all the NSCB protocols can be found at: http://www.lscb.norfolk.gov.uk/

This research was originally carried out between June 2010 and December 2010 and presented at the N-DAP Hidden Harms Forum in January 2011. In light of the author being asked to present it to Norfolk Safeguarding Children’s Board in March 2012, the document has been reformatted and a ‘Progress since January 2011’ section added as a second appendix.
Executive Summary

There is a perception that the awareness of safeguarding and the impact of drugs and alcohol (D&A) on parenting has increased in recent years (due to high profile child protection cases). This research found that in general there is good recognition of the need to ask questions about parenting and substance use; although some professional groups found this more difficult to address than others. These questions are asked as a matter of course through the assessment forms of both social services and drug and alcohol services.

Once these questions are asked people are making the step of assessing whether the level of substance use by the parent is cause for concern (although some groups do not see this as part of their role, employment advisors and supported housing workers). However, the Common Assessment Framework (CAF) is not being used as an assessment tool in all cases as Protocol 10 instructs. Assessments of the impact on the child are happening using a range of formal and informal tools. The CAF is being used (34% of D&A workers surveyed had initiated a CAF and 39% had attended a CAF multi-agency meeting), although it is not necessarily seen as a tool of assessment, but rather as something to provide services when needs have been identified.

Some agencies showed good practice in terms of contacting other agencies to discuss a family when deciding their level of concern. There is good recognition of the need to consider confidentiality, data protection and informed consent, but significant confusion still remains for some around what information can be shared and when, especially with safeguarding concerns below the threshold of serious harm. Increased use of the CAF may mitigate against confusion with the ongoing sharing of information because of the formal structure and clarity around consent.

Safeguarding referrals to Children’s Services are being made, 38% of respondents had made a referral (56% of D&A workers). The decision to refer is usually taken in consultation with colleagues. While some found the Children’s Services consultation line to be useful, others had concerns about the way it is operated. Criticisms were made about the length of time people wait between making a referral and receiving a response. Professionals also reported frustration when they make a referral to children’s services and it is not taken on. There appears to be different understandings of levels of need, what intervention is required and by whom. There is a perceived lack of support or understanding around what they should do when their referral does not meet the Children’s Services threshold for intervention. A central resource that maps the services available to families in Norfolk may help rectify this issue.

When Children’s Services are involved with a family, people do seem to recognise the need to work with them as required. Joint visiting is patchy but does happen sometimes. People do attend child protection conferences (although there are differing accounts of which professional groups get invited/attend), but are critical of getting invited at the last minute and not receiving minutes of previous conferences in a timely manner. There were also concerns voiced about how child protection conferences are run in general. While this is not specifically covered by the protocol, it does affect how people perceive conferences and may impact on attendance.

Reportedly, the quality of written referrals and reports for child protection conferences differs greatly. There is thought to be a lack of training around how to make a good quality referral and this rests on experience. Participants felt the format of NSCB1 form was not always relevant to all the professional groups who use it, and consideration should be given to reviewing this.

Children’s Services are signposting people to treatment but not necessarily making formal referrals. Children’s Services have a very good working relationship with some drug and alcohol treatment agencies but not others; some workers are very satisfied with the level of information sharing although others experience problems (especially in the west of the county).
In general the Protocol is being implemented successfully at an adult D&A treatment agency level policies are in place, attention is given to safeguarding at supervision sessions and staff are being trained. However, more needs to be done in terms of CAF. The DAAT are in the process of updating the adult drug and alcohol treatment agency service specifications, the new service specifications will include a requirement that all staff are CAF trained and that all new staff attend ‘NSCB Substance Misuse within the Family’ training.

A large amount of people have attended NSCB safeguarding training courses and the majority of D&A workers have had safeguarding training. Some people felt this was something that needed to be revisited regularly (every year or three years), which does happen in some agencies and not others. People felt they needed further training on the specific safeguarding procedures such as how to write a good quality referral or report for conference.

Several survey respondents felt that they did not know where their responsibilities lay in terms of safeguarding, and whether it was part of their remit at all. The majority of these were employment advisors and there is a clear training need for this professional group if they are expected to take a role in safeguarding.

There are good relationships between some workers which facilitates excellent examples of multi-agency working and implementation of Protocol 10. However, these are often based on good personal relationships rather than formal procedures. Training is key to the implementation of the protocol; it raising awareness, skills and allows people from different professional groups to meet in an informal setting. A greater shared understanding of different professional approaches, areas of responsibility and better inter-agency relationships are essential to fully implement NSCB Protocol 10.
Aims and Methodology

This research aims to answer these questions:

- Are services that come into contact with substance misusing parent/carers considering the impact of the substance use on the child? Is CAF being used appropriately?
- When people believe that a child may be at risk of serious harm, are referrals being made?
- Are people working with Children’s Services as required by the protocol, sharing information and attending child protection conferences?
- Has Protocol 10 been implemented properly at adult drug and alcohol treatment agency level?
- Are staff properly trained? Are they confident in implementing Protocol 10?

Questionnaire

A questionnaire was conducted to ascertain the opinions and practices of a wide range of people who may identify situations where an adult’s alcohol or drug use could be having an impact on a child. This includes substance misuse workers (in adult and young person’s agencies), GPs, Teachers, Employment Advisors, Housing Advisors, Social Workers, Police, Probation Workers and many others.

The questionnaire was completed electronically using Survey Monkey software, which was emailed out and completed online. This made it easy to fill in and maximised the amount of respondents. The sample was generated through a cascade method; it was sent to communications staff or managers and disseminated to workers. There were 140 respondents to the survey, 64 of these were substance misuse workers and 76 from other professions (these respondents were spread across a range of professional areas, 30% were employment advisors, 17% youth workers and 12% supported housing workers. The rest were made up of health professionals, teachers, probation workers etc.). A separate questionnaire was designed for Norfolk Children’s Social Services staff and was completed by five people.

Focus Groups

In order to explore issues in more depth three focus groups were held; one for drug and alcohol treatment workers (seven attended), one for health workers (nine attended) and one for Norfolk Children’s Social Care services staff (three attended). Although the protocol does cover a wide range of organisations, these groups are felt to be key to safeguarding from a substance misuse perspective. The focus groups were separated on the basis of the attendee’s professional group to facilitate frank and open discussions.

Pro forma for service managers of substance misuse agencies

Recommendation 13 from the NSCB serious case review of CC states, “The NSCB should ensure that the findings of this SCR are brought to the attention of all local agencies and partnerships commissioning drug services to ensure that all such services have clear and effective procedures for safeguarding of children and training for staff in their implementation” (SCR of CC 2009). In order to explore how this recommendation is being addressed a simple pro forma was sent to drug and alcohol treatment service managers to ascertain exactly what safeguarding policies they have, how these are made available to staff and what training is provided.

Managers were also asked to provide two case studies; one which gives an example of the protocol being implemented effectively and one where they feel the situation in terms of safeguarding children did not go as well as it should and the reasons behind that. All DAAT commissioned drug and alcohol services responded to this request apart from NORCAS who declined to be part of the research (although their workers did respond to the survey and attended the focus group).

All participants in the research were assured that their responses would be treated confidentially, in line with data protection requirements, and would not be made attributable to themselves individually.
Chapter 1: Assessment of Need in Cases of Parental Substance Misuse

Awareness on the Impact of Parental Substance Misuse

NSCB Protocol 10 sets out that the possibility that parents have substance misuse problems should always be explored and that the prospect that people with substance misuse problems are parents should always be considered. These considerations should be followed up with assessments about the impact of substance misuse on parenting capability and subsequent impacts on the child.

Appropriate assessments rest on the awareness of general safeguarding issues and the impact of drug and alcohol use on the ability to parent effectively. Participants felt that changes to government guidance and high profile child protection cases have led to a greater awareness of safeguarding issues among the public in general. There is also a perception that there is good general awareness of the impact on substance misuse on parenting, although this is thought to be focused more on drugs than alcohol. A recent report by the charity Alcohol Concern highlighted the issue of parental alcohol misuse and the need for greater awareness and training (Alcohol Concern 2010).

Questions about parental responsibility are included in the assessment form used by all adult drug and alcohol treatment workers in Norfolk (Models of Care), and questions about substance misuse are included in the initial assessment form used by social workers. While questions are routinely asked, there is no guarantee of disclosure. Drug and alcohol (D&A) treatment workers noted that it is unlikely that they would get a clear picture of parental responsibility at that initial assessment:

“People are initially suspicious, they’ll say no because they don’t know what the repercussions are, it’s a trust thing, once he or she gets to know you they’ll say. I think they need reassurance, I think a lot of clients think that if they say they’ve got children that we’re automatically going to refer them to Children’s Services”.

Drug and Alcohol treatment worker

The D&A workers were very much aware of the importance of asking these questions and following up with further questions about risk. Questions of parental responsibility seem to be regularly reviewed and returned to in later sessions.

Of the survey respondents who were not drug and alcohol workers but worked with adults and had identified adults who had drug and alcohol problems, 78% said they would explore whether the client had any parenting responsibility (47 respondents). Of the 13 respondents that said no, the majority (10) were employment advisors who said they would only consider someone’s substance use in relation to their ability to work. The health professionals who attended the focus group showed an awareness of the need to consider drug and alcohol issues, and they reported that when discussing any condition that can impact on someone’s social functioning they would always ask questions about caring responsibilities.

Prevalence of parental substance misuse

Data collected by drug and alcohol treatment agencies and submitted to the National Drug Treatment Monitoring System (NDTMS) shows that in 2009/10 over half of all adult clients are parents (52% or 2343 clients) and 22% of clients (988 clients) had children living with them. The number of children living with each client is also recorded and in total this equates to around 1,900 children living with adults in drug and alcohol treatment in Norfolk. When this field is recorded in NDTMS it cannot be updated and therefore this data rests on what is said at initial assessment. As people can be reluctant to disclose such sensitive information at assessment this figure may be an under representation.

Children’s Services staff estimated that there were substance misuse issues in around 50% of the families they work with, rising to 70% for those with the higher levels of need. This is echoed by the findings of a national survey of social workers which found that they believed on average around 50%
of the clients they worked with had issues relating to drug and alcohol use (Galvani and Forrester 2008).

Assessments of level of concern about substance use
The protocol sets out that in the case of parental substance misuse “the presence of substance use in an adult or child is not an automatic cause for concern, however the level of concern should be assessed.”

When asked whether they made an assessment of the impact of substance misuse on the adult as a parent, 100% the D&A workers said that they did, and 65% of the non-D&A workers. Those who said they did not (27 people) included employment advisors and housing advisors/workers. When asked whether they made an assessment of the impact of parental substance misuse on the child, overall 35% of the survey respondents said no (this represents 40 people), which included 11% of the drug and alcohol workers. However, it was clear from their comments that some people had taken the question to mean formal assessment and others had not.

The Common Assessment Framework (CAF)
Protocol 10 sets out that when a professional is concerned about the level of parents with substance misuse, they should ensure that the Common Assessment Framework (CAF – a universal method of evaluating the needs of a child) is used to assess the needs of the child. The protocol recognises that when the professional is working with the adult they are often not the most appropriate person to carry out the CAF and a conversation should take place between the worker and the parent to discuss who the most appropriate person is to do it.

Participants described various means of assessing their level of concern. These included both formal assessment (using tools, forms, administrative procedures recording concerns and actions) and informal assessments (thinking about it, discussing the case with colleagues). When Drug and Alcohol workers described how they assessed the impact on the child, many cited informal discussion points such as living arrangements, storage of drugs and paraphernalia, checking how child’s needs are met practically. They also said that they speak to colleagues and contact other agencies they know to be working with the family.

Participants also spoke of the advantages of home visits which allows both the client to be more relaxed in a less formal setting, and has the advantage of seeing the home environment. ‘Carers work’ where an employee of a D&A treatment agency works with the family and friends of substance misusers was also thought to have many benefits as they visit the family member in their home, and speak to someone who has a different perspective on the family.

On top of informal assessment professionals described using a range of formal tools, which included DASH forms (referral forms for the MARAC [Multi Agency Risk Assessment Conference] process), SCODA tools (Standing Conference on Drug Abuse) and the NSCB 1 form. One respondent said they use the list of risk and protective factors included as an appendix to Protocol 10. Housing support workers said that they use their local risk assessments to make these judgements. Youth criminal justice workers cited the Onset and Asset tools. Two respondents said they would use CAF, but no-one reported using the pre-CAF assessment tool. So while these assessments do seem to be happening, both formally and informally, use of the CAF is not as widespread as the Protocol dictates it ought to be.
Awareness of CAF
The drug and alcohol workers at the focus group felt very clear about what CAF was for and when to use it:

“Sometimes its obvious that a family have a low level need that wouldn’t constitute being dealt with under the children’s act, for example say mum comes to see us twice a week and that means there’s problems with childcare, and a CAF can be really useful to get other agencies support.”

*Drug and Alcohol treatment worker*

There is still however a long way to go before there is a widespread awareness of CAF. Out of the survey respondents that answered the questions about CAF, 24% did not know what it was (21 of 86) and presumably many of those who did not answer the question also fell into this category. Whether all those that should be aware of CAF are aware of CAF is a question beyond the scope of this research. However, the evidence collected does suggest that CAF is not being used in every case where a child is identified as having parents whose substance misuse is a concern, as instructed by Protocol 10.

Using CAF
Of the 64 drug and alcohol workers who completed the survey, 34% had initiated the CAF process (22 respondents). These were from a range of agencies, including people working in both adult drug and alcohol treatment services and young people’s treatment services. Those that had been in service for longer seemed less likely to have initiated the CAF. 14 people had been in their current role for more than ten years and two of these said they had initiated a CAF (7%). 24 people had been there 3-10 years and 13 said they had initiated a CAF (54%). 39% of the drug and alcohol workers surveyed had attended a CAF multi-agency meeting (25 respondents), and 12% (8 respondents) had been the CAF lead professional (again these were respondents from a range of agencies including those working with both young people and adults). There has been extensive training provided on CAF to a wide range of professionals (see Chapter 6 on training), however, use of the CAF is still believed to be patchy and there are differing levels of use across the county and across different professional groups.

“There’s been lots and lots of training and we’ve got hundreds of professionals trained now, but what happens is they go on the training and they don’t use it, and then they lose their confidence.”

*Norfolk Children’s Social Services worker*

One of the major barriers to starting a CAF was the time consuming nature of coordinating a multi-agency operation, particularly the time it takes to arrange a multi-agency meeting. A recent review of links to mental health services in the county also found similar problems and gave an example of a substance misuse worker making 23 phone calls in order to arrange a CAF meeting (Magilton 2010). Participants in the D&A focus group from Norwich felt that this did not sound unusual. However, the implementation of CAF has not been the same across the county. Great Yarmouth was one of the pilot areas for the CAF and has a dedicated team which comprises a team manager, assistant team manager and two family support workers. They have been jointly funded though Children’s Services, Health and Schools. They give support to the CAF process in terms of setting up meetings, chairing meetings and writing the action plans. As a result there has reportedly been much greater use of CAF in the East of the county:

“I think it works really well for us... we’ve had loads of CAFs raised and we raise CAFs as well... the CAF manager is in very close contact with us all and it just works really, really well”.

*Drug and Alcohol treatment worker*

In other parts of the county implementation has not been as successful, participants felt that while there were people who were confident enough to use it these were generally people in agencies providing services for young people (especially schools). Awareness and use of CAF is not common place for people working with parents. Also, some felt that even though there were many more CAFs
done in the east of the county, there were still questions over how it is embedded with other professionals:

“But what happens when next time that person says ‘You know how to do it, now you do it’ and that’s where the problem is. And some professionals have taken it on really well and others are saying ‘I’m not doing this’. Very difficult.”

Norfolk Children’s Social Services worker

A further barrier to use of CAF is the next stage of the CAF process where the initial meeting has been held and someone is nominated as the ‘lead professional’ to coordinate the CAF. Even those agencies in Great Yarmouth where implementation was good still faced problems when it came to deciding on a lead professional. This was echoed across the county.

“What we’re finding, what the difficulty is with the CAF is lead professional. It’s great going to the initial CAF meeting but if you’re left holding the CAF … when they look round the table and say ‘Who’s involved the most’ you see everyone sitting back – heads down.”

Health worker

“A lot of agencies are fearful of completing the CAF as they think they have to be the lead professional.”

Drug and Alcohol treatment worker

Some participants felt that one of the barriers to CAF was the requirement to gain a parent’s consent if the child is not Gillick competent, however others felt that this was manageable as a barrier and it depended on how it was approached with the client:

“The clients love it, it’s a voluntary process and once they know it’s a voluntary process they don’t pull out because they’re getting loads of support.”

Drug and Alcohol treatment worker

“It’s so acceptable to the family as well; you can sell it to the family so much more easily than you can sell a Children’s Services intervention. It can be done in a very co-operative way in that it’s difficult to do a Section 17 intervention.”

Norfolk Children’s Social Services worker

Information sharing and CAF

NSCB Protocol 10 reminds agencies that they have a responsibility to follow NSCB procedures with regards to information sharing (NSCB Protocol 8). This is based on national guidance, specifically ‘Working together to safeguard children 2006’. The key part of the guidance “identifies the need for the sharing of information as part of a cohesive approach to children at risk and the primary aim is to protect children from harm. Where agencies work together, a more complete picture of a particular case will be evident which will assist in ensuring that the level of risk or harm to any child can be properly assessed and acted upon” (NSCB Protocol 8). The need for agencies to share information with each other was central to the serious case review of CC, which found “at crucial points the liaison between agencies working with adult drug users and those working with children that is necessary to [evaluate in detail the impact of parental substance misuse on the child] was poor” (SCR of CC 2009)

The protocol does not state that people should consider contacting other agencies to discuss a family pre-referral outside of the CAF process. In practice this seems to happen quite regularly. Some professional groups are more comfortable than others with the concept of information sharing. Adult D&A treatment agencies routinely contact other agencies to discuss a family when trying to determine level of risk to the child. Examples were given of situations where they have spoken to the GP, the Family Intervention Project (FIP) and the school in making their decision whether a child is at risk of serious harm and therefore requires a referral to Children’s Services:
“I’d speak to other people concerned, because obviously I’ve met the mother but I’ve never met the child so I need to do that information gathering and then make the decision what then next step it.”

*Drug and alcohol worker*

The health professionals seemed to be comfortable liaising other health professionals and schools:

“If they’re pre-school you’d probably go to health visitor, GP. If they’re school age you’d probably go to the school and school nurse as a point of contact first I suppose and you might find out what other people are involved.”

*Health worker*

On the topic of contacting other professionals prior to making a referral to Children’s Services, one Social Worker felt that they Social Services was often the first point of call, when really they should only be contacted when a person was more certain about their concerns:

“They’d ring up and say to us ‘We’re concerned about this child’ rather than ring [a Drug and Alcohol service] for some advice, to try and quantify their level of concern or quantify the impact of the drug and alcohol use on the parenting.”

*Norfolk Children’s Social Services worker*

There was good recognition of the need to consider confidentiality and the requirements of data protection when contacting other agencies to discuss a family. Health professionals described how the guidance they receive has changed over the years in this respect, with importance shifting to the child:

“My experience has been that people working with adults have clung on to patient confidentiality over children’s safeguarding. Previously anyway, I think its changing.”

*Health worker*

This is an incredibly complex issue given the wide range of agencies covered by the protocol and the highly sensitive nature of issues such as substance misuse and child protection. Issues of confidentiality were perceived to be more problematic for those working with adults than those working with children. Confidentiality was thought to be the main barrier to contacting other agencies to share information, especially when the case was below the threshold of ‘significant harm’. There did seem to be a strong understanding of the need for informed consent except in extreme circumstances. This was cited as the best way of mitigating the detrimental effects to the client-practitioner relationship which are inherently present when child protection concerns are raised. There is a general lack of understanding about exactly what information can be shared and when, especially when the case was below the threshold of ‘significant harm’. Even those who felt they understood it themselves thought that other agencies lacked understanding. The majority of those who had concerns about their own understanding had not attended any child protection training, clearly demonstrating the benefit of training. Some respondents felt that they would be more comfortable raising a CAF as the formality of the procedure gave everyone clear responsibility and the issue of parental consent was dealt with in a formal way.

It is clear that important information can be gleaned from contacting other professionals involved with a family, especially in the initial stages of a case, when deciding level of concern. However, ongoing sharing of information and monitoring of a situation should be happening with the CAF process. Some participants described performing some of the aspects of a CAF outside of the CAF process. When people were waiting for a response to a referral from Children’s Services, or their referral had been rejected, some described calling a ‘professionals’ meeting’:

“Sometimes if they do put a referral in and if there’s a delay and they haven’t got any feedback, then they will call a professionals meeting, they will get professionals around the table and have a semi-pseudo plan.”

*Health worker*
Some respondents gave examples of times where they had called a professionals meeting off their own back and others who were advised to do so by Children’s Services staff to add more weight to the referral:

“There have been times when we’ve thought it’s met the threshold and they haven’t and I’ve called meetings of all the professionals involved with the family, and it’s terrible, but it’s almost about getting enough ammunition and support on your side so it weighs more to try to get them to change their mind.”

Drug and alcohol treatment worker

This seems to be almost an informal CAF and this may be used because of a lack of knowledge about the CAF or could be a response to the perceived bureaucratic, formal nature of the CAF. While this represents good practice and successful multi-agency working, there may be benefits from using the more formal structure of the CAF; this is the process that is set out in Protocol 10. A recent Ofsted report on ‘learning lessons from serious case reviews’ also highlighted the need for information to be shared in a consistent manner, with clear channels of responsibility (Ofsted 2010). If implemented properly the CAF can facilitate this.

Assessment conclusion

There does seem to be good awareness of safeguarding and the impacts of substance use on parenting. In general there is good recognition of the need to ask questions about parenting and substance use, although some professional groups found this more difficult to address than others. These questions are asked as a matter of course through assessment forms of both social services and drug and alcohol services.

Once these questions are asked most respondents were making the step of assessing whether the level of substance use by the parent is a cause for concern (although some groups do not see this as part of their role, employment advisors and supported housing workers). However, the CAF is not being used as an assessment tool in all cases as Protocol 10 instructs. There is clearly a lot more work required to properly embed it into processes among the wide range of professions that it is relevant to. The Children’s Services focus group participants felt that this will happen in time:

“I think in a few years time it will have really taken off, when people get used to it, it’s like any new thing. Hopefully they’ll streamline the paperwork a bit, make it easier for people to set up – not that it’s difficult.”

Norfolk Children’s Social Services worker

The difference between the number of drug and alcohol workers stating that they would use the CAF to assess the impact of substance use on a child (2 respondents) and the number that had initiated a CAF (22 respondents), suggests that CAF is not seen as an assessment tool as such, but rather used to provide services when a need has been discovered. CAF is an important tool for creating a multi-agency team around a child, but should also be viewed as a formal way of making a proper assessment of the needs of the child. It provides a formal structure and clarity for all professionals involved with a family. While a lot of good work is happening in terms of the more informal ‘professionals meeting’, when this sort of activity occurs outside the formal nature of the CAF it can lead to a situation where information is being shared without anyone taking ownership and coordinating the activity. This is highlighted as an issue in many serious case reviews.

Continued focus on embedding CAF in everyday working practices is key to both successful implementation of NSCB Protocol 10 and ensuring the provision of a high quality service to the children of Norfolk. This report recommends that a detailed investigation of the implementation of CAF is conducted to provide a strategy for how to expand its use, potentially using Great Yarmouth as a best practice example.
Chapter 2: Safeguarding Referrals to Children’s Services

NSCB Protocol 10 states that “Any professional who believes that a child may be suffering, or may be at risk of suffering, significant harm, should always and immediately share this with Norfolk Children’s Services” (NSCB Protocol 10). This should either be in the form of a referral over the telephone, using NSCB 1 form or by calling the consultation service.

Just over half of the drug and alcohol workers had referred a family to Children’s Services (56%), and of these 58% thought the response they had received was adequate. Of the non-drug and alcohol workers surveyed, 22% had referred to Children’s Services (17 respondents), and 64% of these thought the response was adequate.

Making the decision to refer

Both D&A workers and health professionals were very clear that the process for deciding whether or not to refer always includes consultation with colleagues:

“Oh no, we always discuss it, even with experience it’s not something you decide on your own. You’d speak to you colleagues informally but then you’d go to the Safeguarding Lead. You’d always talk to someone first. It’s not about one person making a decision, it’s a team decision.”

_Drug and Alcohol treatment worker_

This culture seems extremely positive, as long as it does not delay urgent referrals. The notion that even the most experienced members of staff also have these discussions with colleagues is really constructive for less experienced members of staff. This was done in both formal (team meeting, supervision) and informal ways, which fosters the feeling of openness. Discussing safeguarding cases with colleagues is also seen as important in order to challenge the situation of ‘normalisation’, where a worker gets used to a client’s situation and can loose perspective on the potential impacts of the drug and alcohol use. Participants acknowledged this does happen, especially when they had seen a lot of progress with a client; they felt the opportunity to discuss a case could make them step back and look at the situation objectively. Concerns were raised that if funding decreases, workloads can increase and this means less time for these conversations to happen.

Using the Children’s Services consultation line

If the worker is in need of further advice they can use the Children’s Services consultation line, where they can discuss their concerns with a professional and decide whether a referral is needed. However, some concerns were expressed about this service:

“Sometimes you get someone really good and you get exactly that sort of consultation, it may be that you’re not thinking about making a referral, you’re really thinking about what are the best services to access for this family; but others it’s very much - the questions are around ‘this shouldn’t be a referral’ and you get that batting off feeling right from question one, that their doing their tick box check about why this doesn’t meet their threshold and its not a genuine consultation and advice line.”

_Health worker_

Others were more critical:

“It’s a waste of space. A lot of the time you’ll get passed though to the duty worker who says ‘well if you want to make a referral...but if you’re asking for a consultation, well we’ll take the information but it’ll take 2-3 weeks to get back you’ and you think, ‘Really? Well fine, I’ll just put a referral in then’”

_Drug and Alcohol treatment worker_

Children’s Services staff reported that changes have been made to the way the consultation lines are managed from November 2010. The criticisms raised by participants in this research are clearly well known and improvements have been implemented to address these:
“A new system has been put in place just this last week to try and improve the response so there’s not a delay in giving a response and ensuring all consultation are written up. We’ve increased the volume of managers who are taking consultations and they’re on a rota so when a professional rings in they’ll be passed to the person on the rota that day.”

Norfolk Children’s Social Services worker

It is clearly important to have a well functioning consultation line as it gives people the expert advice they need in a timely manner and reduces the stress of waiting for a formal response. It also allows experts to share their learning and advice, disseminating this knowledge to other professionals. Above all it reduces the amount of referrals that are made to Children’s Services that are then refused, saving time for both the people making referrals and those who deal with them.

Response to referrals

One of the areas people are most critical about Children’s Services is the response they receive to referrals. This manifests itself in two areas, lack of response to referral and refusal to take on a referral. However, while some participants were critical of Children’s Services they usually qualified their criticisms with the perception that social services are:

- Under resourced
- Have a high a turn-over of staff, with some younger, more inexperienced staff because of recruitment difficulties
- Have high administration demands
- Lack of training about drugs and alcohol

The number of referrals to Norfolk children’s services per annum almost doubled from 5,448 in 2008/9, to 9,489 in 2009/10, while the number of initial assessments rose from 3,473 to 4,589. There has also been an increase in the number of core assessments and there were more child protection conferences undertaken in the first six months of 2010/11 than in the whole of 2008/09. There has been no growth in staffing to meet the additional demand, but Children’s Services has been restructured in the hope this will help meet demand (Norfolk Children’s Services 2010).

“I think the really disturbing thing is that when you speak to managers they say ‘all of those referrals are appropriate referrals’. Its not that people are referring in needlessly. You speak to the independent chairs and they say what’s going to conference is appropriate, what’s going on child protection plans is appropriate, we haven’t changed our threshold or how we see those families. We are getting more through the door so it begs the question, what was happening before?”

Norfolk Children’s Social Services worker

“The teams are very, very busy and there hasn’t been an increase in staff, the teams are under considerable pressure, there’s no two ways about it.”

Norfolk Children’s Social Services worker

A national Ofsted survey of children’s social work practitioners found 64% of respondents disagreed that they had time to work as effectively as they would wish to with children and young people. They identified the causes of this as levels of paperwork; time spent recording information electronically and sheer volume of work (Ofsted 2010).

Lack of response to referral

One of the areas where people are most critical of Children’s Services is the response they get to a referral:

“And they are meant to let the practitioner know within a day, that’s the guidelines but the reality of it is 99% don’t get anything. It relies on the individual practitioner being a bit like a terrier really, with the bit between their teeth - continually.”

Health worker
This can be extremely stressful for the worker who made the referral:

“And you often get ‘I haven’t got an allocated worker yet, it hasn’t been looked at yet, its sitting on ... they’re then left holding this because no one wants to do anything with the information that they’ve given them.”

*Health worker*

Waiting for feedback also has other ramifications; it is stressful for the parents, children and other family members as they are also awaiting the result. Furthermore, the worker who has made the referral may need to continue to work with the family while awaiting that feedback and that can be challenging as well as potentially affecting the worker/child’s safety.

**Refusing to take on a referral: Quality of referrals**

Many people highlighted that when they did get the response back from Children’s Services, it was often not the desired response as their referral had not been accepted. Some respondents felt that this may be a result of the poor quality of some referrals. The NSCB1 referral form is a universal form to be used by all professional groups, but some find it does not fit their way of working and therefore makes it more difficult to write a clear referral. While there has been a wealth of training on safeguarding in general there was a perceived lack of training on the particulars of making a referral and providing the information in an accessible way:

“I think one thing we need to get away from is when people write great screeds of narrative, I’ve looked at referral forms and seen some really important piece of information that’s lost in great paragraphs of narrative.”

*Health worker*

They felt that this partly stemmed from a lack of training about how to fill in the referral form well. Experienced workers described the skill involved in writing a referral so that the level of harm they believe is happening is communicated effectively; this included the use of key words and phrases.

Given that Norfolk Children’s Services has seen a huge increase in referrals recently it is more important than ever that those referrals are of a suitable quality. The Children’s Services staff in the focus group felt that in general the quality of referrals was high. However, some professional referrals (especially where the worker works with the adult) lacked specific information about the impact on parenting:

“So just getting referrals saying ‘Well I think so and so drinks, or so and so uses drugs’ is really unhelpful to us because we can’t go to a house and say ‘I hear you’ve been drinking’; so we have to have some information that parenting ability has been affected. We have to have a lot of information.”

*Norfolk Children’s Social Services worker*

**Refusing to take on a referral: Lack of shared understanding of thresholds**

Other professionals felt that referrals were refused not because of a lack of quality, but because Children’s Services do not have the capacity to deal with them. There appears to be a gap between the service that people expect Children’s Services to provide and what they have the capacity to do. Government guidance clearly sets out that protecting children from harm and promoting their welfare depends on a shared responsibility (HM Government 2010). There is clearly a lack of shared understanding about what situations require certain interventions, and where responsibilities lie. Some participants felt certain that they were making good quality referrals that should meet the Children’s Services thresholds for intervention and therefore be accepted. This was cited as one of the major barriers to referring to Children’s Services, the perception that they would not act on it appropriately:

“Our problem is not when they don’t meet the threshold because if they don’t meet the threshold we don’t refer them; we will try and work with whoever. Often they meet the threshold but they just don’t take them on – that’s where the battles come”

*Drug and Alcohol treatment worker*
One participant in the Children’s Services focus group felt that if anything they accepted too many referrals as opposed to too few:

“I think we do an awful lot of initial assessments that personally I wouldn’t have taken on, I think my management take on nearly every referral that comes from drug and alcohol workers as a matter of course, and I think it’s a good thing to do. I don’t like doing them myself unless there is a real reason to go and I think sometimes we go out a bit too readily really.”

*Norfolk Children’s Social Services worker*

However, it should be said that a situation where people are referring too readily is preferable to a situation where people are referring too late, as highlighted by Ofsted in their recent review of serious case reviews (Ofsted 2010).

The protocol makes it clear that when ‘significant harm’ is identified referrals should be made to Children’s Services. However, shared understanding of what constitutes ‘significant harm’ and therefore a need for Children Service’s intervention is not straightforward and does not appear to exist across professional groups. For the protocol to be implemented properly there needs to be a shared understanding of the different thresholds or levels of need. Currently there is a situation where there are different views about what level of need requires what intervention, leading to stress for all parties involved and a loss of confidence in Children’s Services. Protocol 10 says “It is important that all services working with children and adults in a family share information and work together to ensure the needs of both are addressed” (NSCB Protocol 10). This loss of confidence and trust impedes the successful implementation of the protocol.

Some participants felt that at times referrals were not being taken on because of a lack of capacity and there was a particular feeling there was an over-reliance on CAF:

“I think that’s partly because they use CAF more than anything else. The duty team are just inundated, I think you can send a referral but they just say ‘oh no that’ll be CAF’. It makes you question whether CAF is being used appropriately, being used when really it should be a section 17, but instead [they] can pass it onto the lead agency”

*Drug and Alcohol treatment worker*

Children’s Services defend their use of CAF as a response to high demand on their limited resources:

“I think our threshold in Norwich has been high for doing anything under Section 47 because historically we’re under resourced and we struggle to do the child protection let alone anything else. That’s the reality of it I think, so Section 17 work has always been a secondary thing that we do, and we do it quite well with disabled children and asylum seeking children, but with the general population we’re not very good at getting it together because we haven’t got the resources because we’re tied up doing other stuff.”

*Norfolk Children’s Social Services worker*

Children’s Services staff were aware that people thought they were too reliant on CAF. Some felt this could be remedied by expanding the use of jointly funded CAF teams as seen in Great Yarmouth. This means Children’s Services can be more involved in the CAF process, attend CAF meetings to advise and provide support, but still allow other professionals to take ownership. The recent restructuring of Children’s Services has happened alongside the introduction of a new priority matrix, which if implemented properly can improve the shared understanding of levels of need and may help to end the situation where there are disagreements over whether something is CAF, Section 17, Section 47 etc.

“I think there needs to be training around the use of the priority matrix and how professionals use that to assess risk and need before they decide how to respond to that family. And I think if people were using that across the board then people would be, there’d be a greater understanding about is it safeguarding, is it child protection or is it CAF. I think if that training
can happen people would find another way of responding to that family rather than seeing it as ‘oh, Children’s Services’. But that’s a big piece of work to undertake.”

*Norfolk Children’s Social Services worker*

**Advice when a referral is not accepted**

Many participants felt that more support and advice could be provided to professionals when a referral is not accepted:

> “Also, when they say no there’s no advice to what you should do or maybe who might be available to help or who you could go to instead.”

*Health worker*

Children’s Services have a specific remit to deal with cases of need above a certain threshold and therefore will refuse referrals that do not meet this threshold. Given the issues of capacity there needs to be a clear open source resource that Children’s Services staff can direct referring agencies to that contains detailed information about thresholds and crucially what to do in situations where these are not met. This would include details about the CAF and a comprehensive map of the other services that might be available for the family (such as Family Intervention Project, Home Start, Sure Start, Speech therapy etc.). Participants in this research clearly demonstrated that there is a need for such a resource for less experienced practitioners.

**Referral to Children’s Services conclusion**

It seems that people are following up assessment of concerns about parental substance misuse with referrals to Children’s Services as the protocol advises. Decisions to refer are usually taken in consultation with colleagues, and many agencies have a culture of discussing these issues within their organisation and people are clear where they can go for expert advice. Many organisations have safeguarding leads or champions and this best practice should be considered by any agencies who have not already adopted it. It should also be ensured that these safeguarding leads are properly promoted internally and staff are aware of their existence and remit.

However, there are concerns about the response received from Children’s Services in terms of the length of time people have to wait between making a referral and receiving a response. There is also a perceived lack of support around the options available to a professional with a safeguarding concern that does not meet the threshold of Children’s Services intervention. A central resource that maps the services available to families in Norfolk may help rectify this issue. People experience great frustration when they make a referral to Children’s Services and it is not taken on. There is clearly a lack of shared understanding about thresholds for intervention and different understandings of levels of need and what intervention is required and by whom. It is too early to say what effect the restructuring of Children’s Services and the introduction of the priority matrix will have. As always a programme of multi-agency training to create a shared understanding about what needs require what intervention and where responsibilities lie can only improve the situation.
Chapter 3: Working with Children’s Services

NSCB Protocol 10 states, “Safeguarding against significant harm is a multi-agency process and should involve, joint visiting and interviewing, attendance at meetings and conferences, provision of reports (including an opinion about risk to the child) … It is important that all services working with children and adults in a family share information and work together to ensure that the needs of both are addressed” (NSCB Protocol 10).

Joint visiting with other agencies

There are pockets of good practice in terms of making visits to families with partner agencies. Some drug and alcohol workers say they regularly do this while others say it is a rare occurrence. This was thought to happen more in some areas of the county than others (there were concerns raised about the west of the county). Both Children’s Services and drug and alcohol staff discussed the benefits of joint visiting and how useful they could be in terms of openness and a mutual agreement between all parties. Both conceded that while joint visiting does happen, it is not the norm.

Child Protection conferences

The majority of drug and alcohol workers surveyed (67%) had been to a child protection conference. All but one of those working in the sector for ten years or more said they had attended a child protection conference.

There are mixed reports about who should be invited to conferences, who is invited and who actually attends. Some complained that GPs and other doctors were not regularly invited, while others complained that GPs were invited but never attended. There were many differing accounts of the conference attendance of different professional groups. Children’s Services staff in Norwich felt attendance at conferences was generally good (especially of D&A workers) although there were concerns about certain groups such as GPs and Mental Health teams. In other areas of the county there were also concerns about D&A attendance. Children’s Services staff made a point about how helpful they found D&A treatment workers input at conferences:

“What I find really helpful is when we’re discussing problems in the family the key worker will say ‘oh well that’s due to the opiates’. And it gives you more of an understanding of the family you’re working with.”

Norfolk Children’s Social Services worker

It is not within the remit of this research to provide a thorough assessment of child protection conferences in Norfolk; clearly invitation/attendance is an important area, and differing accounts suggest a need for a proper review. There was however some consensus on problems experienced around the administration procedures of conferences, which impacts on whether professionals attend meetings.

When participants were asked if they were invited to child protection conferences the usual response was “Yes but often very late”. The health professionals who attended the focus group described studies that were being carried out locally in their hospitals/practices to audit both who was invited to conference and when invitations were received:

“There is some work going on, I did take this up formally with the LSCB because it was becoming... we didn’t have any that had had a weeks notice or more in quite a long period and I did talk to the independent chair. I’m told the hold up is the social worker telling the independent chairs office. The invitations come from the independent chair’s office.”

Health worker

There are various accounts of why people are only invited ‘at the last minute’, but it seems to stem from requirements of government guidelines:

“There is a requirement to do it within 15 working days of the strategy discussion. Now that’s all well and good if you know who to invite at that point, which often you will do but...”
been given a case recently four days after the strategy discussion, I got it late, had to find everyone out, so I did the invites really late but I have rung everyone up. But yes it happens, and you’re going to get fewer people coming if you invite them late because they’ve got things in their diary of course.”

*Norfolk Children’s Social Services worker*

Working within these strict timescales is difficult but all professionals must remember that government guidance states the requirements of child protection procedures, such as attending child protection conferences, should come before other commitments (HM Government 2010).

Similar complaints were put forward about receiving minutes from the conferences:

“I know it sound like we’re putting them down all the time but the other thing about Children’s Services is their admin procedures, you get the minutes of the child protection conference with the plan attached to it – the last one I got was three days before the next review conference which was three months down the line – how was that appropriate? But that’s par for the course.”

*Drug and Alcohol treatment worker*

The Children’s Services staff agreed that this was unacceptable.

**Provision of reports**

As with invitations there were concerns about how much time was given to provide reports for conferences and the impacts this can have on the quality of the information provided in the report:

“And obviously its an annoyance from my point of view as a worker but for the conference it means your not getting considered information at the conference because I’m not going to be able to write a report with the relevant information with good analysis and all the rest of it because you’re doing it on the hoof, as quickly as possible.”

*Health worker*

There were also more general concerns about the quality of reports. These concerns included a lack of professional analysis and the burying of key facts in screeds of information. These mirrored concerns about the quality of referrals and again the format of the report itself was not necessarily thought to be helpful. Reports are provided on the same NSCB1 form as referrals, although the benefits of having a universal form were recognised. Respondents noted that in other counties different professional groups had their own format for the report. The Children’s Services staff were empathetic with these problems. The scope to change the way reports are provided to conference is a potential area for further work, the Children’s Services at the focus group described recent changes to the format schools use to provide reports to conferences. They suggested changes could be made to the format of the report without too much inconvenience to themselves:

“I think you could do a really simple one that said “We’d like you to write a report for conference, these are the types of things we’re interested in” and trust people to fill out the kind of things they think are relevant. If it’s too prescriptive people will just fill it in like they would any form and not put the energy into thinking about what’s important.”

*Norfolk Children’s Social Services worker*

People also commented that some professionals seemed to lack the confidence to provide information that was critical for the parent/carer. This was thought to be particularly difficult for those working with adults:

“I think there’s a reluctance to link the information to impact on parenting and level of risk for the child. I think that’s still an issue. I think the adult workers see themselves as, there’s a separateness in that they’re working with and for the adult, sometimes it’s difficult for them to look both ways in terms of what’s the impact for the child. And then to own the responsibility to voice what the impact might be.”

*Norfolk Children’s Social Services worker*
“That’s the thing about this process, you know it might produce a better outcome for the children, but you also know it might produce a worse outcome for the parents, for your adult clients – and we shouldn’t forget that, for the people working with the adults it can be extremely difficult.”

Health worker

Some participants raised concerns about times when information provided to conferences was not dealt with properly by all agencies and inappropriately disclosed. Incidents like this were put forward as a reason for professionals being reluctant to provide specific information. Others felt that there was a lack of analysis of the information provided:

“I think that the variation in people’s ability to not only look at the information they’ve brought and that other people have brought but to remain analytical about it and to remain child focused and to have really sound decision making is very variable”

Health worker

Staff from a range of professions criticised the time spent on the child protection plan. Children’s Services staff also voiced general concerns about the way that conferences are run:

“So you go through endless anxiety about whether you arrange the child protection [conference] or not and then when you get to it, it’s so long that it’s difficult to make a sensible plan. I find I come out of conferences with plans that really need a lot of looking at. I would understand other people not coming because I think they’re gruelling meetings and they’re generally hard work in a way that I don’t think they have to be, having been to conferences in other local authority areas and other areas in Norfolk, but in Norwich I think they’re unnecessarily hard work.”

Norfolk Children’s Social Services worker

Although this research used a relatively small sample, these criticisms do suggest the need for a further investigation into how child protection conferences are managed and run in Norfolk, which is beyond the remit of this research.

**Substance misuse at child protection conferences**

The drug and alcohol workers discussed the importance placed on substance misuse at child protection conferences:

“99% of the conferences I’ve been to they always make [our service] - the drug and alcohol issues the number one point, regardless of the home and its conditions, whatever the issue with drugs and alcohol they always make it number one.”

This was discussed in a negative way, borne out of the lack of understanding and perhaps the demonisation of substance use. However, this could be seen as recognition of the potential impact of substance misuse on parenting and the recognised importance of professional input – which would be positive and certainly reflects guidance given in Protocol 10.

**Referring a parent to drug and alcohol treatment**

When asked whether drug and alcohol issues were considered enough at conferences it was felt that it was successful when the key worker was able to have an input, but not everyone with a substance use problem was in treatment. The Children’s Services staff who attended the focus group felt comfortable signposting people to relevant services and were happy with the treatment services provided in Norfolk and felt that waiting times were not excessive. While they seemed to have a good recognition of the need to signpost people to treatment services, there was a lack of knowledge of how to make a formal referral into treatment. The recent safeguarding audit carried out by Norfolk Drug and Alcohol Partnership highlighted the need to create a document detailing referral pathways and local family and parenting services.
Finally while social workers can encourage people to enter treatment, they cannot force them. There are parallels to the situation where other professionals make referrals to Children’s Services that are not accepted and feel they are left dealing with a problem they are not professionally equipped to deal with. Social workers are working with families where there are drug and alcohol issues but the adult is not in treatment and refuses to enter treatment. Unless there is criminal justice element you cannot force someone into treatment, child protection procedures can be used as an incentive to get someone to accept treatment, but otherwise it is a voluntary decision. Social workers can also be left feeling that they are dealing with a problem that should not be theirs.

Information sharing when Children’s Services are involved with the family

The ease of contacting D&A treatment agencies to gain information on families by Children’s Services staff was thought to vary across the county. Staff working in Norwich spoke very highly of the relationship they have with treatment agencies:

“In my experience you can pick up the phone and speak to D&A agencies in Norwich and ask for advice and they’ll be quite happy to give it to you. I think a lot of them have the attitude that child protection trumps everything.”

Norfolk Children’s Social Services worker

They noted that the agencies were happy to share information about clients that they were both working with, that they were flexible in serious situation even if express informed consent had not been given (but significant harm suspected). They also described informal confidential discussions of ‘hypothetical’ families that were not in treatment and the possible impacts of different levels of drug misuse. However, others had had different experiences:

“Sometimes their priority to protect the confidentiality of their adult client has found it hard to be open and honest in order to protect the child”

Norfolk Children’s Social Services worker

“I think in some areas there may be more problems than others. Certainly comments have been made to me that recently there has been a deterioration of joint working with D&A teams and that there is a reluctance of D&A team members to share information and that confidentiality is an issue, and talking about an ‘us and them’ scenario that didn’t used to be the case. It's not as good as it used to be.”

Norfolk Children’s Social Services worker

Drug and Alcohol workers also voiced concerns about getting information from Children’s Services when they found that they were already working with a family. D&A workers felt that while they are happy to share information with Children’s Services it was not always a reciprocal relationship:

“My biggest bugbear with them is time and time again you can ask for their input and they’ll invite you on to meetings and stuff like that, but if it’s a case they’re already working on and you ask them for information – you don’t get it, you don’t get it at all. And then you go to a conference, you end up being number one and you feel this sudden massive responsibility – it can be a bit one sided”.

Drug and Alcohol treatment worker

One theme that reoccurred in discussions at focus groups and in the questionnaire was that the services received differed widely across the county. It was felt that Children’s Services staff also varied across the county and also within localities:

“I knew if I get a certain social worker that I’d get a positive response, if I spoke to others I possibly wouldn’t. And it shouldn’t be that way ... there needs to be a more standardised response.”

Health worker

Good examples of multi-agency working seem to rest on personal relationships between workers in various agencies rather than formalised procedures. While some people felt that their agency works
very well with Children’s Services others had very different experiences. Again, it seems that individuals have had varying experiences in different areas of the county and that the cultures in the various treatment agencies and social work localities also differ. It seems that where personal relationships exist they are very successful and there is no need for formal procedures, however, if these relationships do not exist it is very difficult to create them without formal procedures at least in the first instance. It was suggested in the Children’s Services focus group that this may take the form of attending each others’ team meetings. Other ways may include multi-agency training and programmes of professional shadowing.

Working with Children’s Services conclusion

People do seem to recognise the need to work with Children’s Services (indeed the greater problems seem to be where they want greater Children’s Services involvement in a case and they do not receive it). Joint visiting is patchy but does happen sometimes. People do attend conferences (although there are differing accounts of which professional groups get invited/attend), but are critical of getting invited at the last minute and not receiving minutes in a timely matter. There are also criticisms about the way conferences are managed, the lack of professional challenge and the use of research. The importance of substance misuse is recognised at child protection conference; Children’s Services staff are signposting people to treatment but do not formally refer. They cannot force people to attend treatment and are sometimes left feeling that they are dealing with a problem that they are not professionally equipped to deal with. Children’s Services has a very good working relationship with some D&A agencies but not others; some workers are very satisfied with the level of information sharing but others experience problems.

The high demands on Norfolk Children’s Services capacity at a time when funding may be reduced will have a knock-on affect on other agencies. Safeguarding children is everyone’s responsibility but if the amount of appropriate referrals to Children’s Services continues to increase it may create a situation where other agencies are expected to take a greater role in safeguarding and this may put pressure on other services. The difficulty faced by agencies that come under the banner of universal services is that they have to provide services in a way that ‘threshold services’ like Children’s Services and mental health services do not:

“Well we’re universal services you see, we are there [laughs] we can’t say no. When you’re in somewhere like CAMHS, somewhere Tier 3 you can put that cross at the door and say ‘no, no, no you need to go to such and such’ but we are there, that’s why we have universal services.”

Health worker

This leads to highly stressful situations like the one described below

“We had a situation with a young person last week who needed housing and they came out and saw her and said ‘no we can’t do anything’ and left! And we were left with ‘Well what can you do, surely you can do something’ and they said ‘well no we can’t, we’ve got no money and ...’ they leave it with you.”

Health worker

Successful implementation of Protocol 10 rests both on professionals being aware of substance misuse issues and making safeguarding referrals as appropriate, but it also rests on the assumption that Children’s Services has the capacity to deal with these referrals. If there comes a time in the future that they do not, it will have significant implications for the implementation of Protocol 10.
Chapter 4: Implementation of NSCB Protocol 10 at a Substance Misuse Treatment Agency Level

Recommendation 13 from the NSCB Serious Case Review (SCR) of CC states “The NSCB should ensure that the findings of this SCR are brought to the attention of all local agencies and partnerships commissioning drug services to ensure that all such services have clear and effective procedures for safeguarding of children and training for staff in their implementation” (SCR of CC 2009).

Assessments of parenting responsibility are included in the Model of Care universal assessment form, which is used by all N-DAP commissioned services for every new client. The Models of Care form has recently been reviewed and updated, questions around safeguarding have been made more robust and additional guidance has been provided. Confidentiality issues are clearly addressed through the Models of Care form, this means that these discussions happen with all clients as a matter of course. Some agencies also have an additional confidentiality statement which they ask clients to sign. Staff were clear about the importance of informed consent but also that there were circumstances where this was not possible or in the best interests of the child.

Each service has either a local safeguarding policy or uses one of their parent agency; for example Norfolk Criminal Justice Intervention Team (CJIT) is part of the Norfolk and Suffolk Probation Trust and therefore is compliant with their procedures. Local policies are in line with NSCB policies and are regularly reviewed and updated. No agency has carried out a specific case audit in regards to safeguarding but some agencies did report that they look at this as part of more general case audits.

Safeguarding information is disseminated to staff in a number of ways; it is a specific part of the induction for new staff at some agencies (Matthew Project, TADS, and CJIT). All agencies said it was something regularly addressed at team meetings and as part of supervision. CADS have specific safeguarding supervision as well as regular supervision. Most agencies stated that safeguarding was also addressed through informal discussions. Health based agencies such as CADS, TADS and Matrix project attend mandatory PCT based training, this is updated every three years. They also encourage more specialist safeguarding staff to attend NSCB training courses. CJIT staff attend mandatory training run by the probation trust. All Matthew Project workers attend safeguarding and CAF training.

The DAAT is in the process of updating the adult drug and alcohol treatment agency service specifications. The new service specifications will include a requirement that all staff are CAF trained and that all new staff attend LSCB Substance Misuse within the Family training.
Chapter 5: Training

The protocol does not cover training; however, successful implementation of the protocol would be supported by sufficient training on safeguarding/child protection including the affect of substance misuse.

Since 2008 Norfolk Local Safeguarding Children’s Board has run 24 ‘Core Child Protection’ courses and 567 people have attended this course. This includes a wide range of health professionals, social care staff, teachers, nursery workers and other school employees (such as attendance officers), youth workers, police and probation officers and many others, including 24 substance misuse workers. Also since 2008 seven ‘Substance Misuse within the Family’ courses have been run, training 138 people. Again this has been attended by a range of professions including a large amount of social care staff, health professionals (including 13 health visitors) and seven substance misuse workers. There are still a few courses to be run, although after March 2011 the way NSCB provides training is likely to change but at the time of writing further details of this had not been released.

In total 4470 people have been CAF trained in Norfolk since 2005 (3299 since 2008). This includes 633 from voluntary sector organisations (including some drug and alcohol treatment workers) and 444 from community/primary health (including drug and alcohol treatment workers in clinical agencies). CAF is also covered extensively in the DAAT run course ‘Young people, drugs and alcohol, what should I do? Part 2’ which has been attended by approximately 75 people in 2010/11.

**Substance misuse workers**

**Safeguarding training**

Of the 64 substance misuse workers who responded to the survey 81% (52 respondents) had had training on the impact of drug and alcohol problems on safeguarding children. Of the 12 who were not trained, six were from Trust Alcohol and Drugs Service (TADS), two from the prison Counselling, Assessment, Referral, Advice and Throughcare (CARAT) team, two from NORCAS, one from Norfolk Criminal Justice Intervention Team (CJIT) and one from The Matthew Project. This represents a reasonable spread of the sample as the greatest amount of responses came from TADS (the largest agency overall). Of those who had had safeguarding training 87% said they had used the training. Most of those who had not had training felt it would be useful to have.

**CAF training**

55% (35 out of 64) of the substance misuse workers surveyed had been trained in the use of CAF, again most of the agencies were represented in both respondents who said yes and those who said no, this is apart from CJIT and CARAT where no respondents had been CAF trained (however this does only represent five workers). All of the respondents from the youth services said that they had been CAF trained. If you separate the sample by youth and adult workers (youth workers could be said to be expected to be CAF trained as standard) the figures of adult workers are 50/50 trained and not trained. Of the 35 who had been CAF trained 60% said they had used the training. This is lower proportion than those who said they had used the more general safeguarding training.

Of the 29 who had not had CAF training four said specifically that they would like to be CAF trained. One respondent said that they had been trained on CAF on three occasions and had been given different information each time. This person felt there lacked a consistent approach to CAF and the way it is implemented has changed over time.

**Further training**

Of those who had been trained in safeguarding several said that they would like a refresher of their child protection training and felt that it was something that needed to be revisited regularly. One respondent who had attended several NSCB course including ‘Substance misuse within the family’,
felt that they needed “more in depth about what constitutes child protection and what doesn’t when it comes to parental substance misuse” (Drug and alcohol treatment worker). One respondent who had been on the core NSCB course felt they needed more information about confidentiality in relation to safeguarding.

Induction
88% (56 of 64) had been inducted into local safeguarding procedures. Of the eight who said they had not two were from CARAT, one from Matthew Project Under 18 and five from TADS. Those who said no are spread evenly across the ‘lengths of time in service’.

In general the standard of safeguarding training among the drug and alcohol treatment agencies is high, with a large number saying they had made use of the training. Levels of CAF training are lower but still with a small majority being trained. There is still a desire for more detailed training on what is certainly a highly complex and multi-faceted issue.

Non-substance misuse workers.
76 respondents completed the survey who were not substance misuse treatment workers. These respondents were spread across a range of professional areas, 30% were employment advisors, 17% youth workers and 12% supported housing workers. The rest were made up of health professionals, teachers, probation workers etc.

Safeguarding training
Of these 62% (47) had not had any training on the relationship between adult substance misuse and safeguarding children. Most of the youth workers had been trained (9 of 13). Only one of the 23 employment advisors that completed the survey had any training on parental substance misuse and safeguarding; nor had the majority of supported housing workers (2 of the 9 had been trained). Although these are not representative samples, it suggests there are key people who are involved with families and covered by Protocol 10 who have not been trained in safeguarding and substance misuse. Of those who had not had training, 74% said that they did not feel comfortable that they knew their responsibilities in terms of safeguarding where parental substance misuse is a concern. Of those who had had training only 7% (2 of 29) said they did not feel comfortable.

62% of those who had done safeguarding training said that they had used it. Health professionals, supported housing workers and a teacher (as well as the one employment advisor who had been on training), were among the 38% who said they had not used the training.

CAF training
37% of non-substance misuse workers had been trained in use of CAF. Among these were youth workers, teachers, health professionals and supported housing workers. Of those who had been trained on CAF, 47% said they had not used it. This suggests that there may be some way to go in terms of embedding CAF.

Induction
58% of non-substance misuse workers had been inducted in local safeguarding policies. 21 of the 23 employment advisors had not been inducted. All of the health professionals and the supported housing workers had, as had the teachers. So again there seems to be a gap in this area for employment advisors.

Further training
Health professionals felt that they received a good standard of basic safeguarding training and had good awareness of safeguarding, but needed further information on more advanced areas such as specific details on how to fill in the NSCB1 referral form well. They did feel that they also could benefit from more training on drugs and alcohol. Health professionals also raised concerns about
their lack of knowledge of prescription medications and the implication this can have for child protection.

Joint multi-agency training was highlighted time and time again as the best way to respond to the multitude of concerns raised. Not just for the training itself but the opportunities to meet staff in other agencies and form connections.

“It’s about knowing the people you’re dealing with in other agencies, you develop those relationships and also you have an understanding about people’s roles and responsibilities and the challenges and terminology and all the rest of it. I think more training on drugs and alcohol, and having shared training and more training and having those links can’t be anything other than beneficial.”

Health worker

Several survey respondents felt that they did not know where their responsibilities lay in terms of safeguarding, and whether it was part of their remit at all. The majority of these were employment advisors and there is a clear training need for this professional group if they are expected to take a role in safeguarding.

Training of social workers:
The level of awareness of drug and alcohol issues among social workers is thought to vary greatly. Norfolk Drug and Alcohol Team (NDAAT) have an active role in training social workers in Norfolk. This year NDAAT used part of its training budget to provide two days of training for social work students on placement, which included basic information about drugs and alcohol and more detailed information about parental substance misuse, dual diagnosis and drugs and the law. NDAAT is also involved in an enquiry based learning model and provided two two-hour sessions for students that had chosen substance misuse from a menu of options. NDAAT also provided a number of training courses to the people of Norfolk free of charge, which are accessed by social workers.

Galvani and Forrester (2008) carried out a survey of newly qualified social workers and found that the majority did not feel prepared for working with drug or alcohol use. They also found that nearly 70% of the social workers studied had received one day or less training on substance misuse. Currently the social work degree curriculum covers generic skills such as communication and assessments, and does not contain requirements for subject areas; this is left to the discretion of the university. In general the training provided in Norfolk is more than is received by many social work students and relies on active engagement by the NDAAT Training and Workforce Development Officer. The Social Work Reform Board is undertaking a review of the degree curriculum in England and is considering making substance misuse a compulsory part of initial training (Taylor 2010). A recent poll by the General Social Care Council found that 89% of those surveyed want the social work degree to include training on substance misuse (Gaston and Kahlfan 2010). A lack of knowledge about drugs and alcohol could have a serious affect on the service provided to the client family:

“But because she had so little knowledge the impact she had on the family was huge because she came down on them like a tonne of bricks because she was like ‘I don’t know what to do so I’ll do absolutely everything’ and that was terrible.”

Drug and alcohol treatment worker

“I think the social workers that I’ve dealt with in children’s services, they’re always asking for more knowledge around drugs and alcohol and its affect on people, that kind of basic… if they go to someone’s house and they’re looking a bit… what could it be? That kind of basic stuff.”

Health worker

Four of the five respondents to the Children’s Services survey felt that they had sufficient knowledge of substance misuse to make informed judgements of the families they are working with. While the Children’s Services staff that attended the focus group felt that they personally had sufficient knowledge, they also felt that this was patchy amongst colleagues and noted that while the training
was available it was not compulsory or given as standard. Problems with ensuring staff were trained were compounded by high staff turnover. However, it was also felt that for staff who had not been trained it was their responsibility to find out the issues affecting families they are working with and that they have access to a wealth of open source information and could utilise other’s expertise:

“Certainly if you pick up a referral and it says that the biggest problem in that family is drugs and alcohol then it falls to that practitioner to find out about it doesn’t it? They don’t need to be taken and trained about it in order to do it; they should be making those inquiries and getting the information themselves.”

Norfolk Children’s Social Services worker

Sufficient levels of training may help combat the impact of stigma. A recent UKDPC report exploring the detrimental effects of the stigma of drug use on the recovery outcomes for people with substance misuse problems described social workers as stigmatising insofar as they interpret every infringement, such as being late for an appointment, which for other people would be considered a minor matter, as being related to drug use or a sign of continued drug problems. They also found that social workers appear reluctant to understand the process of recovery, and gave the example of social workers telling parents they would have greater access to their children if they met the goal of refraining from drug use for six months, only to be told to wait another few months. Not surprisingly this can lead to relapse and a self fulfilling prophecy (UKDPC 2010). These sorts of attitudes that can be combated by training can clearly have a huge impact on recovery potential and therefore the outcomes for the children.

Training conclusion
In general the standard of safeguarding training among the non-substance misuse staff surveyed was lower than the substance misuse staff (38% compared to 81%). Levels of CAF training are also lower (37% compared to 55%). While there seems to be a sufficient basic level of knowledge about safeguarding, there is a desire across different professional groups for more detailed, skills based training. This includes further training on the procedures and processes of child protection, especially Norfolk Children’s Services thresholds for intervention and what to do when the case does not meet that threshold, when to use CAF and how to write a good quality referral/report for conference.

Although all workers should be encouraged to use their initiative to expand their learning as they see fit, the prevalence of parental substance misuse and its impact on safeguarding children suggests a need for compulsory training. Consideration should also be given to how often this training is refreshed; in some organisations training is repeated every three years, where as others only do it once. The need for regular, good quality and preferably multi-agency training is clear and this is a priority for the successful implementation of Protocol 10.
In some ways the protocol is being implemented well, particularly with regards awareness of safeguarding responsibilities. Implementation of the protocol has been complemented by recent events that have led to increased public awareness about child protection and the affect of substances (particularly alcohol) on safeguarding. A key element of the successful implementation of Protocol 10 is the perceptions of responsibility for safeguarding/child protection in general. Traditionally people consider that all child protection concerns should be dealt with by Children’s Services, official guidance sets out the safeguarding is everyone’s responsibility and perceptions are changing.

There is still some way to go to fully implement the protocol, particularly with regards to CAF. It seems that people are thinking about child protection, thinking about the affects of substance use and whether they should make a referral. They are assessing their concerns, although not necessarily using CAF. People are in a situation where they feel they have done their duty, made a referral and feel like someone else should then take over managing the support of that family. However, when referrals do not meet the threshold for Children’s Services and they feel they are left ‘holding’ the problem. The agreed process for providing services at this level in Norfolk is by using the CAF. Those who have used CAF seem happy and can see the benefits, but there is still a general perception that it is a time consuming, complicated process, and this is a big barrier to its use.

When children’s services are working with a family, many professionals do accept their responsibility to be involved. Joint visiting is patchy but does happen sometimes. People do attend conferences (although there are differing accounts of which professional groups get invited/attend), but are critical of getting invited at the last minute and not being given enough time to provide reports. There are also criticisms about the way conferences are managed, the lack of professional challenge and the use of research.

In times of hardship and reduced capacity effective multi-agency working is the key to continued service provision. The issues of thresholds will in part be addressed by the restructuring of Children’s Services and only time will tell what affect this will have. In any case the restructure has not happened alongside an increase of Children’s Services capacity; if anything capacity may reduce as budget cuts bite. The kind of multi-agency working advocated by the protocol is one way to mitigate against the worst affects of these cuts. This research has uncovered some really good areas of practice operating in certain areas and between certain individuals, which without doubt is in line with Protocol 10. Questions have been raised on how widespread this is, with particular concerns being raised in the West of the county. The danger of a system based on personal relationships is that people eventually change roles or leave (and this will increase with changes to structure and funding), and these relationships are lost. More formal arrangements would be beneficial to help foster these personal relationships. Multi-agency training is key to successful implementation of the protocol. Not only does this raise awareness of, and the skills to deal with, safeguarding situations but facilitates people from different professions meeting and sharing experiences in an informal way. A greater shared understanding of different professional approaches, areas of responsibility and better inter-agency relationships are essential to fully implement NSCB Protocol 10.
References


Magilton, Shirley (2010) “Effectiveness of mental health and/or substance misuse related joint planning processes and practice” (Available on request from Jonathan Stanley, CAMHS Strategic Commissioner, jonathan.stanley@norfolk.gov.uk)


Women's National Commission (WNC) (2009) “Still we rise: Report from WNC focus groups to inform the Cross-Governmental Consultation ‘Together we can end violence against women and girls’”

http://www.ukdpc.org.uk/resources/Getting_serious_about_stigma_overview.pdf
Appendix 1: Protocol 10 Parental Substance Misuse Flowchart

Does the adult have substance misuse issues?

Yes

Does the adult have caring responsibilities or regular contact with a child?

No

No further action.

Yes

Assess the level of concern you have about the adult's substance use.

Assess the adults needs as a parent.

Concerned

Consider consulting the Young Peoples Integrated Substance Misuse Service (Matthew Project Under 18) to discuss using the Common Assessment Framework (CAF) to assess the child.

Consult other agencies you know to be working with the family to discuss concerns (including Children's Services to see if the family is known to them).

Consider making a home visit to the family.

If Children's Services are involved with the family, work with them as required.

Based on these assessments, choose a course of action:

No further action required.

Make a referral to Children's Services.

Use the CAF process to provide services to the family.

Referral accepted - Work jointly with Children's Services as required.

If your referral does not meet the Children's Services threshold for intervention - consider contacting other family support services.

If at anytime you suspect the child may be suffering, or at risk of suffering, serious harm please contact Children's Services immediately.

NOTE: If the adult is pregnant please refer to NSCB Protocol 23 (Pre-Birth Protocol)
Appendix 2: Progress since January 2011

This research was commissioned as part of N-DAP’s Safeguarding Action Plan. A range of actions have been carried out to improve safeguarding in the case of parental substance misuse; the following are specifically relevant to this research:

• N-DAP is recommissioning the adult substance misuse treatment system in Norfolk and safeguarding has featured prominently in the service specification; this includes the requirement to have a clear safeguarding policy, to complete a quarterly safeguarding reports and for all staff to complete relevant safeguarding training.

• NSCB Protocol 10 has been rewritten to make its guidance clearer and easier to follow. Some elements of the protocol have been adjusted to bring it in line with common practice, for example suggesting the professional contacts other agencies they know to be working with the family to discuss concern before completing CAF. Also the Protocol makes it clear that while the CAF is the optimal way of assessing the needs of the child, it does not have to be carried out in every case.

• Flowcharts have been created, again to make the protocol easier to follow.

• The safeguarding page on the N-DAP website has been developed, based on the Parental Substance Misuse Flowchart, to provide links to advice and guidance at each stage of the process, including links to relevant assessment forms and other services that are available to families.

http://www.nordat.org.uk/Redesign/help/someone/safeguarding/safeguardingchart.html

Next steps: Following NSCB ratification of the updated Protocol 10, N-DAP will promote it widely to raise awareness around the roles and responsibilities of all professionals who come into contact with parental substance misuse. The recommissioning of the adult substance misuse treatment system (new service to begin from October 2012) is an excellent opportunity both to raise awareness of Protocol 10 with staff, and also to raise awareness of the procedure of referring an adult to treatment with social care staff.